Bayou Health Provider Call – Summary
February 4, 2015

FOLLOW-UP ASSIGNMENTS	
1. Pregnancy Application Processing	See follow up in Q&A below
2. Protocol for Erroneous Assignments	
3. MCO Eyewear Policies	
4. Protocol for Billing an Emergency claim for a non-participating Provider	
5. Universal TPL Form	

Meeting Facilitator:
Mary TC Johnson, Deputy Medicaid Director

DHH Announcements

- DHH is posting provider call summaries on www.makingmedicaidbetter.com. The previous summaries on this website contain a list of provider communication sources. DHH requests that providers utilize these sources to communicate with the MCOs.
- DHH is still working on the Informational Bulletins that were promised on previous calls. In particular the 39 week elective deliveries and the mixed service protocol that will go into effect on March 1, 2015.
- DHH will have a call specific to behavioral health similar to the one for personal care services last Friday.

Bayou Health New Contract Period:

- New contracts went live on 2/1/15. Members previously in shared savings plans are now enrolled in full Managed Care Organizations.
- DHH experienced some glitches in the auto assignments during this implementation.
    - Approximately 600 children who were born in January were assigned to CHS as this was their mother's plan at the time. These children remained in CHS after 2/1/15. Most of these have been corrected. If a provided finds a member in CHS on their eligibility file, let DHH know and it will be retroactively corrected.
    - Pharmacy recipients who were previously members of a UnitedHealth's Shared Plan were still receiving benefits through Molina and not through their new Managed Care Organization. The management entity for United Health pharmacy is OptumRx and there was an issue with pharmacies requiring the OptumRx/United ID to fill a prescription. This issue has been resolved. If a member presents with their Medicaid ID number, the pharmacist can bill for the prescription and it will update with the OptumRx number as well.
- Keep in mind that it is the provider's responsibility to verify eligibility every time a service is provided. Providers should check REVS or MEVS by entering the member number, swiping the card or calling to verify eligibility. This is how providers will verify which Health Plan a recipient is enrolled in and with whom prior authorizations should be coordinated.

- The contracts have transition of care requirements for the MCOs. All prior authorizations approved will be honored for 30 days. The MCOs will need to work with the providers and members to get new prior authorizations in place. Providers will be responsible for seeking the new prior authorizations, as well. The 30 day period is for all services except for pharmacy. Pharmacy benefits will be honored for a 60 day period for the same medication, dosage and quantity. If there is a change in dosage or quantity, a new prior authorization will be required.

Questions & Comments

Q: *If a member is admitted to a rehabilitation center with a pending Medicaid application awaiting determination of the eligibility, what should the provider do?*
A: The provider accepts the risk when providing the services in this situation. If determined eligible the member can be retroactively certified. The Bayou Health Plan will be responsible for the first 12 months of retroactivity. Any claims past 12 months will go to Molina for processing. This information is in the Provider Summary from last week as well. DHH cannot give a blanket statement that claims will not be denied because there are other valid reasons for denial, such as the service may be a non-covered service or may not meet the medical necessity requirement for approval. There must be some agreement mechanism in place for the provider to bill the MCO. Lastly, the service may be a non-covered service.

Q: How does the ability to use member identification numbers (MID#) for processing work?
A: If a member walks into a pharmacy and does not have the Pharmacy Benefit Management number, the pharmacy can still check eligibility. If the pharmacist has the MID#, they must be able to process the claim using that number. DHH spoke with United and OptumRx and the correction is in place. If a provider finds that is not the case, let DHH know.

Q: Will enrollment be broken out into geographic areas? Do you have enrollment numbers available?
A: All Health Plans are statewide. DHH does publish enrollment data but I am not sure how it is broken down. Please send an email to bayouhealth@la.gov and it will be routed to the enrollment section to provide you with a response.

After Call Response: *Enrollment figures can be found online at www.MakingMedicaidBetter.com in the "Reporting and Accountability" portal. Here is a direct link to the enrollment data: http://www.dhh.la.gov/index.cfm/page/1377/n/313. Enrollment reports are provided in a variety of ways – by parish, by plan and parish, new enrollments, transfers, etc.*

Q: What is the update with United Health not allowing DME providers in their network?
A: DHH spoke with United Health executives including the CEO. DHH requires that they build an adequate network. United is still in conversations with providers but they are not required to contract with every DME provider. They must provide an adequate network statewide in the time required and at the price that DHH pays, unless the provider agrees to a different rate. United indicated that they are willing to have discussions with providers to meet local needs.

Q: What should the patients do who are currently receiving services with a DME provider who cannot contract with United?
A: Any prior authorizations for the first 30 days will be honored.

Q: In the question above, what about after the first 30 days? Where will these patients go to obtain services?
A: Patients should be instructed to contact United member services and they will find an in network provider for them.

Q: Was the informational bulletin about circumcisions developed?
A: It has not been developed yet. In general it is covered for newborns. DHH will have to clarify if it is within so many days post birth. Also, will it be covered if the child is born 30 days or a certain number days prior to 2/1/15? DHH will need to look at this.

***After call response**: DHH is not publishing a standing Informational Bulletin on circumcisions as the information is subject to change and verification by the MCOs; however we are publishing the policies as they stand today as an attachment to these notes.*

Q: What information is available on Aetna's vision services? Where do we submit materials for eyeglasses and so forth? Should it go to Molina?
A: No. If the member is enrolled with Aetna then it should go to Aetna. Medicaid covers more vision services for children than adults and each Health Plan has initiated valued added services for adults. These services vary from plan to plan. On the notes to last week's call there is a link for contacts to all five (5). Providers should utilize that link to get billing and contract information.

Q: If a provider is currently assigned with Aetna commercial, do they need to re-contract?
A: Yes. Providers must contract with Aetna Medicaid to provide services. Go to www.Making MedicaidBetter.com to get information on contracting with the Bayou Health Plans.

***After Call Response:** The direct link to Bayou Health Plan provider relations and contracting contacts can be found here: http://www.dhh.la.gov/index.cfm/page/1461.*

Q: Will Aetna Medicaid cards look different than Aetna commercial cards?
A: Yes. The cards will look different. Providers will have some indication that it is an Aetna Medicaid compared to commercial Aetna. The representative will email the provider a copy of the new card.

Q: I am unable to set up electronic billing with Aetna. Why isn't Aetna required to be set up to accept electronic billing?
A: Electronic billing is a requirement for all the MCOs. Send detailed information to bayouhealth@la.gov and DHH will have Aetna reach out to you to work on this issue.

Q: Will Aetna's card be updated on the informational bulletin?
A: Yes

Q: Will Long Term Care be a part of Bayou Health?

A: This service is still Fee for Service. Members are not allowed to participate in Bayou Health.

Q: Provider sent a network request several times and claims are still not getting through, should we be in network by now?
A: Send details to bayouhealth@la.gov and DHH will send the issue to Aetna to resolve and track through resolution.

Q: Where should providers submit billing for Aetna?
A: Send details to bayouhealth@la.gov and DHH will send the issue to Aetna to resolve and track through resolution.

Q: If a provider had a PA prior to implementation that expires in February and the provider is having difficulty getting a new PA, will it still be covered?
A: Yes and no. If you haven't made the request for a new PA, then the PA probably will not be covered.

Q: If the PA expires today and the patient comes tomorrow would it be covered?
A: In general a PA is only valid through the date of approval. You will need to contact the MCO to get a new PA for continued services.

Q: Why are we having issues with rejections of high dollar medications that we could work through in the past? Is there a change causing these medications not to be covered?
A: It is possible that there has been a change. For the first 60 days, the MCO must continue to pay pharmacy.

Q: The 39 week amendment form is sent to vital records for approval and updates, does the form also need to go with the claim?
A: I don't have an exact answer. There is an informational bulletin regarding this on www.MakingMedicaidBetter.com. Look to the Informational Bulletin tab on the left hand side of the page.

Q: Does UHC have to relink all of their former patients; all of the doctor's patients have disappeared except for 2?
A: UHC took the provider's information and will contact him offline.

Q: A patient contacted the Bayou Health customer service line to change Health Plans and was told that she was not allowed to change It was my understanding that members are being given the opportunity to switch. Is that correct?
A: There was a window of opportunity where members could not switch. As of 2/1/15 members can switch until 4/29/15. Members should call 1-855-229-6848 to change with an effective date of 3/1/15 for this month.

Q: In the above question, this was a pregnant mother, who needs to change to stay with her current doctor and hospital through delivery of her baby; will she be able to stay with them?

A: She should be able to stay with the provider and hospital. The provider will have to work with the plan if they do not have a contract. The provider should send the detailed information securely to bayouhealth@la.gov. DHH can pull the tape and listen to the conversation with the customer service representative. Mary indicated that she received verification while on the phone that DHH staff is already working on this issue as it was brought to their attention prior to the call.

Q: Is there a quick reference guide for prior authorizations on DME claims?
A: We don't have that information specifically online. The problem with providing online links is that often the information is quickly outdated. It is best that providers reach out to the Health Plans directly.

Q: Are any of the Health Plans still authorizing and processing through Molina?
A: No. Molina only processes information for members who are not in Bayou Health Plans. There is an Informational Bulletin or Health Plan Advisory pending for DME. Any claims with dates of service prior to 2/1/14 still go to Molina. If the member is enrolled with an MCO, then the MCO should be billed.

Q: Patients are coming to us with two insurances and it is hard to get the information updated in the file so we can bill for the claims. What should we do in these situations when Medicaid is secondary?
A: There is a backlog on some of the TPL information due to changes with the contractors. TPL information should be sent to the Health Plans.

Q: What should be done when the TPL information and Medicaid information has different identification (such as different names) causing the primary insurance to indicate that the recipient is not insured?
A: Please send this information via secure email or fax. Send several examples along with the Explanation of Benefits from the primary insurance, the denial notice and some claim examples. DHH will look into this.

Q: Why isn't UHC contracted with any of the hospitals in our area? Where members should be sent in our area for x-rays?
A: The Health Plan will reach out to the provider concerning this issue.

Q: Where is TPL information sent to be updated? The information should be sent to Danny Murnane. DHH is working on a universal form to be used by all parties to notify of TPL information

After Call Response: *The link for the universal form containing all TPL contacts and fax numbers is* www.dhh.louisiana.gov/assets/medicaid/MedicaidEligibilityForms/TPLUpdate-Providers2-10-15.pdf

Q: Are there any changes concerning prior authorizations?
A: Prior authorizations differ for each plan.

Q: What about changes regarding inpatient authorizations?
A: Some of the confusion around the inpatient process is that some type of review is still required but administratively we have waived the prior authorization process on the fee for service side. The caveat that I want providers to be aware of is that if there is any other reason for the claim to deny, it can still be denied. For MCOs you still have to prior authorize inpatient stays but for fee for service claims prior authorizations have been waived.

Q: Will the 180 timely filing apply to third party claims? Is it 180 days for Medicaid secondary as well?
A: This is across the board. Timely filing is 180 days. It is the intent that it be for Medicaid secondary as well but DHH will need to circle back. The issue is still under review and will be determined if it will be upon receipt of the explanation of benefits or initially.
After call response: 180 days from date of services does not apply to third party subrogation claims.

Q: What was the need to change timely filing from a year (365 days) to six months (180 days)?
A: DHH made this decision. There were actually requests to go to an even shorter timeframe or to allow the MCO to determine their own timeframe. DHH felt a shorter period would not work as it did not allow an extra timeframe to go back and do something on the Medicare, TPL and would cause delays in getting encounters in administratively. State to state this timeframe is very similar.

Q: Where do we send non-Molina TPL information?
A: We will have staff find out and post the information.

Q: Can you update the fax numbers for those who are Molina?
A: I will have the document include information for all the Health Plans and fee for services. Fee for service TPL information should be faxed to 225 342 1376. It should also be faxed to the MCO. If it is a member with an MCO, it should only be sent to the MCO. The information needs to go to the responsible party.

Q: Will the MCOs develop their own TPL form?
A: I recommend that we keep the same form and put all six fax numbers on the form.

Q: Are Aetna and UHC considered shared plans?
A: We have no more shared health plans. All services included in Bayou Health will be provided by the MCO. There will be no more DME carve out.

Q: Does this mean that authorizations for these members will not go through Molina?
A: With the exception of the carved out services such as dental or Adult Long Term Care. Again, DME will go to the Health Plan.